**NHS North East Essex CCG Primary Care Ophthalmic Services**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |

**Referral Form** NHS No:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Mr/Mrs/Miss **Patient** | **GP** | **Referring Clinician** |
| Last Name |  |  |  |
| First Name |  |
| Address |  |  |
|  |  |
|  |  |
| Postcode |  |  |
| Phone and Fax |  |  |
| Date of Birth |  | Professional Reg No. |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral to:** | | **Glaucoma Refinement Service** | | **OPSI**  **Refinement Service** | | | **Secondary Care** | | **For GP Information** | |
| **Urgency:** | | | 🞏 Routine | | | 🞏 Urgent | | 🞏 Emergency | | |
| **Clinic Required** | | | 🞏 Cataract | | | 🞏 Glaucoma | | 🞏 Paediatric Ophthalmology | | |
| 🞏 Cornea/Contacts | | | 🞏 Low Vision | | 🞏 Diabetic/Medical Retina | | |
| 🞏 External Eye Disease | | | 🞏 Ocular Motility/sqint | | 🞏 Vitreo Retinal | | |
| 🞏 YAG Laser | | | 🞏 Oculoplastic/Lacrimal | | 🞏 General Ophthalmology | | |
|  | Sph | | Cyl | | Axis | VA | Pin Hole | IOP | | 🞏 NCT  🞏 GAT  🞏 Perkins |
| R |  | | - | |  |  |  |  | |
| L |  | | - | |  |  |  |  | |
|  | | | | | | | | | | |
| **Visual Fields**: 🞏 Normal 🞏 Abnormal | | | | | | | | | | |
| **C.D. Ratio:** | | | | | | | | | | |
| **Findings:adf** | | | | | | | | | | |
| **Diagnosis:\dad**  **Diagnosis By** (*Please Circle)***:** Optometrist/OPSI Refinement Service/Glaucoma Refinement Service/GP | | | | | | | | | | |
| The patients consent to information being exchanged between clinicians has been obtained: 🞏 | | | | | | | | | | |
| **Referring Clinicians Signature: Date:** | | | | | | | | | | |

|  |
| --- |
| **GP Action:** |
| **Attachments including**: 🞏 Medications and relevant history 🞏 Visual Fields |

V1. February 2014